PN-ABX-084

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Setting Priorities for Research, Analysis, and Information Dissemination on

POPULATION AND FAMILY PLANNING IN AFRICA

PN-ABX-084

A Strategic Framework for Setting Priorities for Research, Analysis, and Information Dissemination on Population and Family Planning in Africa

Prepared for the

Bureau for Africa

Office of Sustainable Development

by the

Health and Human Resources Analysis in Africa (HHRAA) Project

with technical assistance through the

Support for Analysis and Research in Africa (SARA) contract

June 1995

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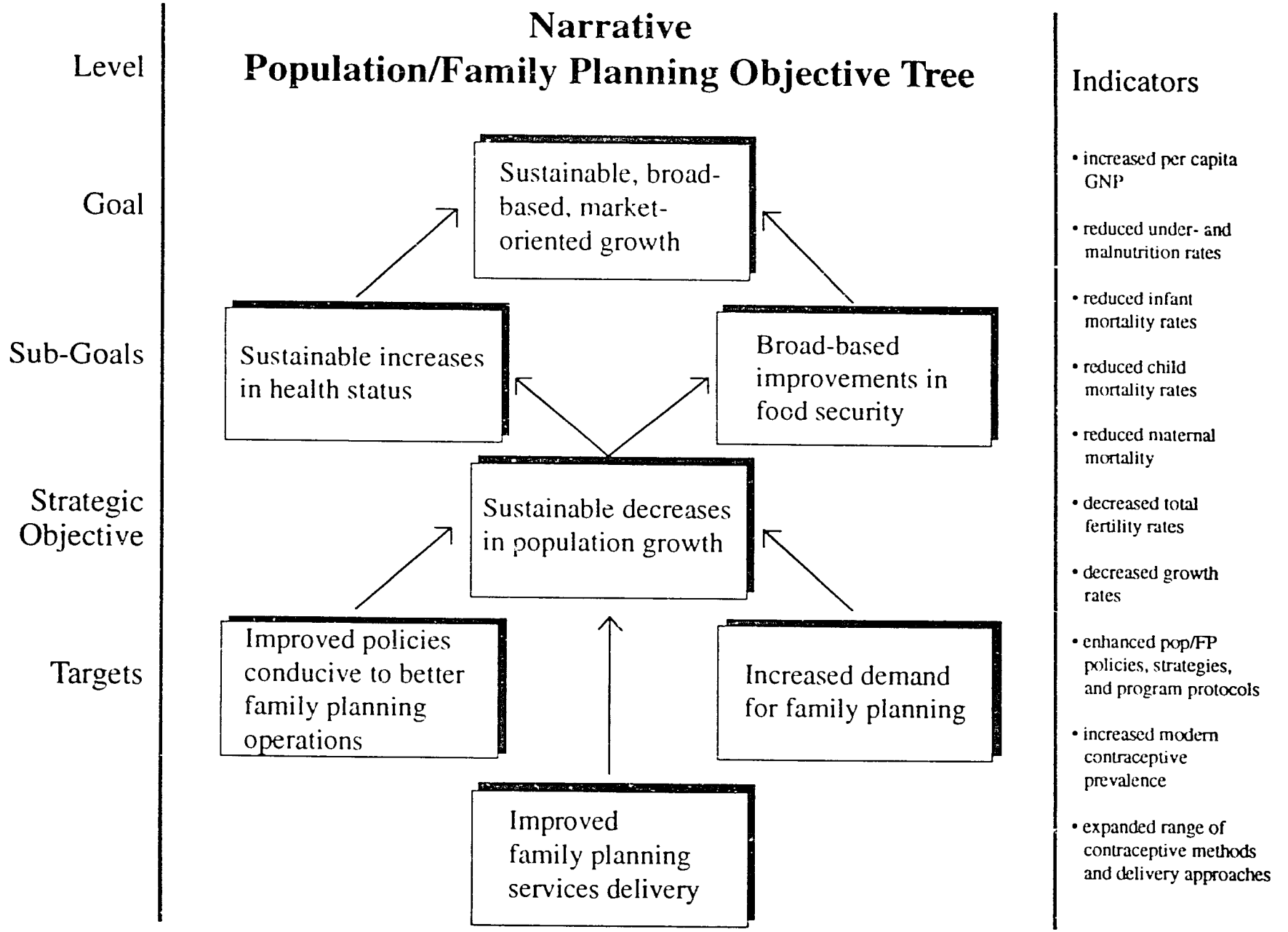

Executive Summary

The Office of Sustainable Development (SD) of the Bureau for Africa emphasizes regional-level activities that influence the strategic resource allocation and operational decisions of USAID, African governments, the private sector, and other donors. The goal is to increase the effectiveness of the broad range of resources available for African development. The Health and Human Resources Analysis for Africa (HHRAA) Project, in the Human Resources and Democracy (HRD) Division of the SD Office, has been authorized as a mechanism to increase research, analysis, and information in support of improved strategies, policies, and programs.

In population and family planning, the Bureau for Africa works within a broader agency strategy, which focuses on four principal objectives:

- to help couples and individuals exercise their internationally recognized rights to determine freely and responsibly the number and spacing of their children;
- to improve individual reproductive health, with special attention to the needs of women and adolescents;
- to achieve population growth rates consistent with sustainable development; and
- to establish programs that are responsive and accountable to the people who use them, especially women.

This strategic framework has been developed to guide the Bureau in selecting analytic activities. The framework contains the following sections: (1) a population objective tree; (2) a brief background summary of the importance of this analytic area; (3) the purpose of the framework; (4) a ranked listing of potential topics identified to date; (5) criteria for prioritization; (6) the framework rationale including a review of information needs and gaps; and (7) a list of potential approaches to address priority needs.

To ensure greater impact, AFR/SD/HRD devoted a significant amount of time over this last year to identifying priority issues for Africa, as well as information needs and gaps, in population and family planning. The process included a review of current AFR/SD/HRD analytic activities; formal consultations with African decision-makers, cooperating agency representa-

tives, and USAID field staff; formal and informal literature reviews on potential issues; and organized discussion groups with population experts. The Bureau also created a population objective tree that provides a framework for assessing how sector-level targets will contribute to the overall Development Fund for Africa strategic goals and objectives (see page v).

During the issues identification process, a number of topics consistently emerged. These topics were reviewed and ranked by consultative group members, USAID staff, and African family planning and reproductive health experts. Priority issues identified thus far are:

- Adolescent Reproductive Health
- Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access
- Gender Issues in Family Planning
- Strengthening Reproductive Health Services: Integrating Family Planning and STD/HIV/AIDS Programs
- Post-Abortion Management and Family Planning Service Provision
- National Population Policies
- Vertical and Integrated Approaches to Family Planning Programs

This framework also contains a rationale and a description of information needs for family planning cost and financing issues, and for two additional issues that cross-cut several sectors: program decentralization and manpower deficits.

Each year, the AFR/SD/HRD Office will draft an analytic agenda using the strategic framework as a reference. Because research, analysis, and dissemination activities need to be demand driven, the Bureau for Africa will revise and update this framework as new information and requests are presented by African population experts and decision-makers and USAID mission and field staff.

Acronyms

AIDS	acquired immune deficiency syndrome
APAC	African Population Advisory Committee
AFR/SD/HRD	Africa Bureau, Office of Sustainable Development, Human Resource and Democracy Division
AVSC	Association for Voluntary Sterilization Council
CA	cooperating agency
CERPOD	Centre d'Etudes et de Recherche sur la Population pour le Développement (Centre for Applied Research on Population and Development)
CPO	Center for Population Options
CRHCS/ECSA	Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa
CSM	contraceptive social marketing
DHS	demographic and health surveys
FHI	Family Health International
FLE	family life education
FP	family planning
FPA	Family Planning Affiliates (UNFPA)
G/PHN/POP	Global Programs, Field Support and Research Bureau/Center for Population, Health and Nutrition/ Office of Population
HHRAA	Health and Human Resources Analysis for Africa
HIV	human immunodeficiency virus
IEC	information, education, and communication

INTRAH	Program for International Training and Health
IPAS	International Project Assistance Services
IPPF	International Planned Parenthood Federation
IUD	intra-uterine device
JHPIEGO	The Johns Hopkins Program for International Education in Reproductive Health
KAP	knowledge, attitudes, and practice (survey)
NGO	non-governmental organization
OC	oral contraceptives
OPTIONS	Options for Population Policy
PAI	Population Action International
PRB	Population Reference Bureau
PSI	Population Services International
RAPID	Resources for the Awareness of Population Impacts on Development
REDSO	Regional Economic Development Support Office (USAID)
RTI	reproductive tract infection
SARA	Support for Analysis and Research in Africa
SOMARC	Social Marketing for Change Project (The Futures Group)
STD	sexually transmitted diseases
UN	United Nations
UNFPA	United Nations Population Fund

USAID	United States Agency for International Development
WHO	World Health Organization

Background

In 1960 African population growth rates were not high compared with those of Asia and Latin America (2.5 percent per year vs. 2.5 and 2.9 percent, respectively). Today, however, Africa's has risen to 3.0 percent while Asia's and Latin America's have fallen to 2.1 and 1.9 percent. The growth rate has remained high because mortality rates have dropped and the fertility rate—the average number of births per woman—remains exceptionally high, more than six. Since 1965 the total fertility rate has decreased only about 5 percent, from 6.7 to 6.4 births per woman.

According to UN estimates, at least 45 percent of the population is under age 15 in most African countries. This large proportion of children creates a built-in momentum for future population growth. Even if fertility were to drop immediately to replacement level, the region's population would still increase by an estimated 250 million people by the year 2025.

This extraordinary population surge will be accompanied by massive pressures for social services, food security, and jobs at a time when governments are facing a number of crises: economies are stagnating, external indebtedness is mounting, and people are becoming poorer. Addressing these issues will become more strenuous in the face of competing demands for national and international resources, restructuring of domestic economies, and emergence of other problems such as AIDS, environmental degradation, rapid urbanization, and growing numbers of unemployed, disillusioned youth. In summary, population growth is outpacing the ability of economies to expand, thus swamping Africa's development efforts.

Furthermore, high fertility rates are an enormous impediment to improving maternal and child health in sub-Saharan Africa. Many infant deaths could be prevented through birth spacing: babies born less than two years after a sibling are almost twice as likely to die as those born after an interval of at least two years (Population Reference Bureau (PRB) 1991). Maternal mortality could also be dramatically reduced through greater use of family planning. At 640 deaths per 100,000 live births, women's death rates from pregnancy and childbirth in Africa are the highest in the world.

Not only can family planning provide immediate health benefits to mothers and children, it also contributes to significant cost reductions in health and education services. For example, as a result of Zimbabwe's successful fam-

ily planning program, 1.3 million fewer student-years of primary school education were required between 1965 and 1990 than would have been required if 1965's high fertility rate had continued. At an average cost of $110 a year of primary school education, the savings to the government and the people of Zimbabwe were more than $140 million. Likewise, at an average cost of $16 to fully immunize a child, the savings to the immunization program alone was nearly $23 million (The Futures Group 1992).

Currently, the U.S. Agency for International Development (USAID) is responding to the development challenges of the 1990s by focusing efforts in four areas critical to sustainable development: broad-based economic growth, the environment, population and health, and democracy. New strategies have been developed for each area that emphasize support for sustainable and participatory development, partnerships, and integrated approaches, with special attention to the needs and roles of women.

Specifically, in the area of population assistance, USAID is now operating under renewed U.S. leadership and a supportive policy environment. Priority family planning needs in the 1990s include catching up with unmet need, currently estimated at 120 million women in the developing world; keeping up with the growing demand for family planning; and satisfying current users by ensuring wide availability of quality services (Maguire 1993). There are also tremendous reproductive health challenges that are inextricably linked to the promotion and expansion of family planning counseling and services. These challenges include lowering pregnancy-related morbidity and mortality, reducing unsafe abortion—frequently a consequence of unmet need for family planning—and preventing and treating sexually transmitted diseases (STDs), including HIV/AIDS.

The USAID's Bureau for Africa recognizes that only a few African countries have made progress in establishing comprehensive reproductive health services, increasing contraceptive prevalence rates, and reducing fertility. Thus, the bureau aims to work within the broader agency strategy, focusing on the three principal objectives that have guided USAID's population assistance program since its inception: to enable couples to freely choose the number and spacing of their children; to reduce maternal, infant and child mortality; and to bring population growth rates in line with sustainable development.

Purpose of the Strategic Framework

This strategic framework defines the priorities of the Office of Sustainable Development (SD) of the Africa Bureau and the Health and Human Resources Analysis for Africa (HHRAA) Project for supporting research, analysis and information dissemination related to population and family planning. Both the SD Office and the HHRAA Project emphasize improving policies, strategies, program design, implementation, and evaluation in health, nutrition, education, and population. Their purpose is to provide timely and appropriate information to USAID offices, African governments, non-governmental organizations, and donors that will assist them in making appropriate decisions about setting priorities and allocating resources.

Increasingly, African countries are establishing national population polices and are beginning to appreciate the importance of integrating demographic variables into development plans and objectives. However, turning these stated objectives into effective actions remains elusive. Policy makers, program planners, and donors need critical information to enable them to make effective decisions. Many questions must be addressed concerning mobilizing human and financial resources; implementing a broader approach to family planning and reproductive health; designing quality programs with maximum access; and building a broader constituency. All of these areas directly relate to issues of vital importance to SD and HHRAA such as increasing use of research to affect policies and programs, increasing the efficiency of investments, and reaching key policy makers and opinion leaders. By analyzing and disseminating existing data and lessons learned, and by helping to fill in the information gaps identified during the last year, SD and HHRAA can make substantial contributions to policy, program, and operational decisions throughout the region.

Objectives

To fulfill its commitment to leadership on population issues, USAID will give priority to four major objectives (Atwood 1993):

- to help couples and individuals exercise their internationally recognized rights to determine freely and responsibly the number and spacing of their children;

- to improve individual reproductive health, with special attention to the needs of women and adolescents;
- to achieve population growth rates consistent with sustainable development; and
- to establish programs that are responsive and accountable to the people who use them, especially women.

The Africa Bureau's proposed population and family planning activities directly address these objectives. Specifically, the objectives of research, analysis, and dissemination in this area are:

1. Identify and promote policy and program changes that will improve service delivery and enhance quality of care.
2. Reduce unnecessary barriers to family planning access by supporting the updating of service delivery and training guidelines.
3. Strengthen reproductive health services by examining the organizational, program, technical, and financial implications of service integration.
4. Increase demand generation by promoting policies and program approaches that encourage contraceptive use by special groups—adolescents and youth, men, post-abortion clients, and rural and urban poor.
5. Help ensure long-term financial sustainability of family planning and reproductive health programs.
6. Facilitate incorporation of population and family planning information, research into policies and programs by
   - supporting innovative dissemination approaches;
   - documenting and disseminating experiences about research application; and
   - developing tools to help decision-makers understand the policy and program implications of analytic and research findings.

These objectives are consistent with the strategic objective of sustainable decreases in population growth and the three targets listed in the population/family planning objective tree (see p. v): (1) improved policies con-

ducive to better family planning operations; (2) improved family planning services delivery; and (3) increased demand for family planning.

Issues Identification

The issues identification process for population was initiated in December 1992 in a brainstorming session attended by population experts including USAID/W representatives, a member of the African Population Advisory Committee (APAC), and HHRAA staff. The resulting preliminary list of key topics was subsequently reviewed in the field by various USAID mission and REDSO staff and a number of prominent African specialists at the African Regional Population Conference in Dakar, Senegal.

Approximately 20 key topics emerged from these discussions. To facilitate identification of specific information needs, the Support for Analysis and Research in Africa (SARA) staff conducted an extensive literature review and produced an annotated bibliography of each topic along with a summary discussion of key issues relevant to sub-Saharan Africa. These documents were then used as background materials for a consultative group meeting held in May 1993. The group, made up of six African population specialists and 24 experts representing nine major cooperating agencies, G/POP, G/Health, and the Africa Bureau, identified and ranked a large number of potential research, analysis, and dissemination activities. The Africa Bureau shared these potential topics in questionnaire form with participants at the Population Council's end-of-project Operations Research Conference held in Nairobi, Kenya, October 6-9, 1993. The result is a priority listing of population issues from some of Africa's leading family planning experts. This list is attached in the Annex and is reflected in the section on prioritization of information needs.

In addition, a number of key regional institution staff members provided valuable insights into the Africa Bureau's issues identification process over the last year. These groups include APAC, the Centre for Applied Research on Population and Development (CERPOD)—representing the nine member states of the Sahel subregion—and the Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa (CRHCS-ECSA). This framework also benefited from the recommendations included in six studies on population dynamics in sub-Saharan Africa recently produced by the National Academy of Sciences and presented at an international conference held in Washington, D.C., in July 1993.

Basis for the Strategic Framework: Prioritization of Information Needs

The following criteria have been selected to establish the priorities of the ARTS office and the HHRAA Project for supporting research, analysis, and dissemination activities in the population and family planning sector:

- linkages to the AFR/ARTS population sector objective tree;
- regional significance;
- USAID and the Africa Bureau's comparative advantage over other organizations in working in this area;

and, to avoid duplication,

- complementarity with ongoing USAID programs and the activities of other donors/institutions.

To assist with the development of a priority list of activities, each of the above-mentioned criteria has been applied to the most important topic areas that emerged over the last year during the issues identification process.

Priority topics identified thus far are:

- Adolescent Reproductive Health
- Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access
- Gender Issues in Family Planning
- Strengthening Reproductive Health Services: Integrating Family Planning and STD/HIV/AIDS Programs
- Post-Abortion Management and Family Planning Service Provision
- National Population Policies
- Accelerating Urban Family Planning Programs
- Vertical and Integrated Approaches to Family Planning Programs

Adolescent Reproductive Health

Linkages to the Objective Tree

Focusing on the establishment or expansion of programs aimed at this important target group primarily supports two of the objective tree targets: improved family planning service delivery and increased demand for family planning.

Regional Significance

The rapidly escalating number of youth constitutes one of the single most compelling challenges for sub-Saharan Africa. Today, there are nearly 188 million young people between the ages of 10 and 24. By the year 2025, that number is projected to increase by another 246 million, bringing the total to 434 million (PRB 1992). Currently, in some parts of Africa between one-third and one-half of young women have a child by age 19. Clearly the number of pregnancies, and probably abortions, will increase dramatically, along with the incidence of STDs and HIV infections. Many African experts believe that changing sexual attitudes and behaviors and reducing disparities in gender roles and responsibilities will be achieved best through provision of information, counseling, and services in the early, formative years.

USAID/Africa Bureau's Comparative Advantage

Currently, the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) have a limited focus on selected country-specific projects working primarily with government agencies and institutions. African experts suggest that USAID's history of working with governments as well as private sector organizations gives it a comparative advantage in being able to (1) mobilize more broad-based support, and (2) capitalize on regional experiences with a variety of family planning delivery modes that lend themselves to expansion of adolescent and youth services (e.g., community-based and social marketing programs).

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- IPPF is coordinating pilot "youth-to-youth" projects in Senegal, Egypt, and Sierra Leone. The program aims to empower young

people to promote and produce their own teaching and information materials in local languages. IPPF is also encouraging family planning affiliates (FPAs) to remove legal, educational, and physical obstacles by assisting governments to develop sexual and reproductive health policies.

- UNFPA primarily works with government programs to support formal and non-formal population education programs such as strengthening family life education and information, education, and communication (IEC) projects.

- The Center for Population Options (CPO), sponsored primarily by UNFPA, Ford, and Population Action International (PAI), supports youth programs in Africa by offering seed grants and technical assistance to help groups initiate programs; working with professionals, policy makers, and the media to focus attention on adolescent reproductive health issues; and developing curricula for use by programs.

- The Rockefeller Foundation has recently developed a reproductive health strategy that focuses on abortion care and STD services for adolescents under 20 years of age. The strategy emphasizes two types of research activities: documentation research to supply missing evidence about the nature and magnitude of the risks, illness burden, resource drain, and need for services; and intervention research to test models for delivering reproductive health services.

- Population Action International, through CPO's Seed Grants Program, supports youth programs in Nigeria and Kenya, and helps sponsor the Centre for the Study of Adolescents in Nairobi.

- Family Planning International Assistance works with youth programs in Lesotho, South Africa, Zambia, and Zimbabwe. The group's activities include enhancing family life education (FLE) programs, establishing youth advisory services, creating teen education programs with NGOs, and linking family planning services to youth programs outside the clinic setting.

Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access

Linkages to the Objective Tree

Efforts to reduce barriers to family planning access will have a positive impact on all three objective tree family planning targets. Medical barriers are defined as "practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception" (Shelton, Angle, and Jacobstein 1992). Major medical barriers include inappropriate contraceptive eligibility criteria and excessive laboratory testing prior to providing contraceptive. Removing these barriers, and other unnecessary hurdles such as provider bias or unjustifiable restrictions on who may provide contraceptives, directly affects policies conducive to improved family planning service delivery. Moreover, elimination of restrictive policies and program level protocols likely will result in increased client satisfaction, with a strong potential for increasing demand.

Regional Significance

Although many countries are beginning to eliminate access restrictions, concerns about quality issues and the role of allied professionals persist. Owing to isolation and lack of current scientific information, particularly in francophone Africa, progress has been slow. Potential approaches to priority needs in this area include region-wide questionnaire sampling and periodic conferences involving participants from a number of subregional countries. These approaches enhance the possibilities of cross-country analyses and promote exchange of experiences among technicians and decision-makers. By focusing on the removal of barriers, family planning services—particularly nascent programs—may be able to accelerate service expansion.

USAID/Africa Bureau's Comparative Advantage

A member of the HHRAA Project's technical assistance consortium, The Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), has extensive experience in working to reduce medical barriers throughout the world. JHPIEGO has participated in regional medical barriers conferences in Asia and Latin America, and was the lead agency for this year's Anglophone Africa conference (January 1994). In addition, because of the number of USAID-supported cooperating agen-

cies (CAs) currently involved in medical barriers activities, the Africa Bureau is being asked to share costs and build on existing initiatives rather than create new projects or accept the entire financial responsibility of any one activity.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

A number of collective activities are currently in process:

- The Global Bureau's Office of Population (G/PHN/POP), in collaboration with WHO and IPPF, is working to develop a set of guidelines to identify process hurdles and promote a more epidemiologically and programmatically rational set of eligibility criteria. Group members are focusing on process issues associated with contraceptive initiation (Norplant, minilaparotomy) and management of side effects.

- G/PHN/POP, in collaboration with representatives from selected CAs in population, established a working group to collect country-level information on restrictions to access from health, population, and nutrition (HPN) officers worldwide. The group has completed a preliminary assessment of 43 responding countries.

- A third working group, initiated by G/PHN/POP, is carrying out organized educational events, primarily through a series of Contraceptive Technology Update regional conferences. An anglophone sub-regional conference in Zimbabwe (partially-funded by the HHRAA Project) took place in January 1994. A regional francophone medical barriers conference is under discussion.

Gender Issues in Family Planning

Linkages to the Objective Tree

Promoting greater male involvement in family planning and developing a better understanding of couple interactions is primarily linked to one objective tree target--increasing demand for family planning.

Regional Significance

Traditionally, family planning programs in Africa have largely targeted women. The emphasis appears to be changing, however, as more national family planning program managers recognize the importance of men's roles and motivation in fertility decision making and prevention of STDs. The importance of examining gender issues is receiving additional reinforcement because of a new regional emphasis on family planning as a fundamental right of both sexes, and sexual decision making as the joint responsibility of partners. To date, no country program appears to be initiating activities in a systematic fashion. Operations research projects and further analysis of existing programs are needed to give decision makers and program managers a basis for developing comprehensive strategies.

USAID/Africa Bureau's Comparative Advantage

USAID has a long history of supporting programs that provide family planning and HIV/AIDS prevention information, services, and supplies to men. These male involvement programs have included contraceptive retail sales (Population Services International (PSI), Social Marketing for Change Project, The Futures Group (SOMARC)); employment-based education and services (Enterprise, TIPPS); mass media promotion of family planning directed at men; and use of male village distributors in community-based distribution programs. Largely through USAID-funded social marketing programs, condom sales have increased dramatically in anglophone and francophone countries. Doubtless much of this increase can be attributed to concern about AIDS, but the increased attention to condoms has also increased their use as a family planning method. USAID could capitalize on its marketing and media experience to expand efforts in gender-related research and promoting male involvement and couple interactions.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- IPPF provides technical assistance and financial support to FPAs primarily to develop IEC campaigns aimed at increasing awareness and knowledge among men; promote condom use; and conduct KAP surveys.

- Association for Voluntary Surgical Contraception (AVSC) recently established a program office devoted to male involvement in fam-

ily planning worldwide. Its activities in Africa include supporting a new all-male clinic in Nairobi and completing a series of vasectomy decision-making studies in Tanzania, Kenya, and Rwanda.

- The G/PHN/POP Office supports the Contraceptive Social Marketing (CSM) III Project (The Futures Group), which is currently working to establish broad-based contraceptive retail sales (particularly condoms) and mass media promotional campaigns in seven sub-Saharan African countries.

- Population Services International has several agreements with USAID missions to conduct social marketing of health and family planning products. PSI, currently operating in 15 sub-Saharan African countries, also works to combat AIDS through IEC campaigns and the promotion and distribution of condoms.

Strengthening Reproductive Health Services: Integrating FP and STD/HIV/AIDS Programs

Linkages to the Objective Tree

Although the advantages and disadvantages of program integration are still unclear in sub-Saharan Africa, experiences in other regions suggest that integration, particularly at the client level, could improve the efficiency and effectiveness of family planning and reproductive health services. To the extent that providing integrated services is perceived as increasing service quality, activities associated with program integration could have a positive impact on family planning demand.

Regional Significance

First, scarce resources in sub-Saharan Africa mandate careful examination of the potential benefits of program integration. Second, the significance of this topic is accentuated by the growing incidence of HIV infection throughout the region. Infections of the reproductive tract—including the common STDs and HIV/AIDS—are of central concern to policy makers and providers of health/FP services as these infections influence the safety and quality of programs, the prevalence of infertility, and the impact on the demand for fertility regulation, and drain limited government resources. Much remains to be learned about the feasibility, cost, and outcomes of integrating services.

USAID/Africa Bureau's Comparative Advantage

USAID has extensive experience in designing and implementing family planning services and increasing experience in management and prevention of sexually transmitted diseases (JHPIEGO, PSI, Population Council, FHI, CSM III). USAID bilateral assistance agreements frequently include support to health and family planning programs, thus USAID can facilitate implementation of a broader approach to reproductive health services.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- IPPF/Western Hemisphere Region (WHR) sponsors an STD/HIV prevention program designed to improve the ability of FP providers to meet the sexual and reproductive health needs of clients through the integration of FP and STD services. Integrated projects are being implemented in six countries in the Caribbean and Latin America.

- According to IPPF representatives for Africa, IPPF is addressing this topic through country-level FPAs in Africa. To date, IPPF has provided limited guidelines: provision of HIV/AIDS/STD information in IEC programs; provision of condoms; and education of staff about infection control. The program seeks to establish dialogue at the community level between FPA staff and community members regarding sexual behavior and attitudes.

- WHO has produced guidelines on AIDS and family planning for MCH/FP program managers (World Health Organization (WHO) 1990).

- The Rockefeller Foundation recently developed a reproductive health strategy. Focusing on STDS, the strategy emphasizes two types of research activities: documentation research to supply missing evidence about the nature and magnitude of the risks, illness burden, resource drain, and need for services; and intervention research to test models for delivering reproductive health services.

- Since 1989 JHPIEGO has been working with WHO to adapt simplified, problem-oriented approaches to managing sexually trans-

mitted genital tract infections for use at the primary, secondary, and tertiary levels. Training materials have been developed and field tested in Morocco and Kenya.

Post-Abortion Management and Family Planning Service Provision

Linkages to the Objective Tree

Collecting primary and secondary data that illustrate the magnitude and cost of the problem, and promoting effective post-abortion management linked to quality family planning services contribute to all three population targets: supporting policies conducive to better family planning operations, improving family planning services delivery, and increasing demand for family planning.

Regional Significance

Since unsafe abortion is a leading cause of disease and death among women of reproductive age in Africa, providing post-abortion management, counseling, and family planning services is a high-impact area of concern. Evidence indicates that, in general, the target group—women who have had abortions—is not receiving effective contraceptive information or post-abortion family planning services.

USAID/Africa Bureau's Comparative Advantage

USAID plays a major leadership role in population and family planning that strongly influences actions and priorities throughout the world. The problem of abortion-related morbidity and mortality has long been neglected. African experts and other donors believe that if USAID focuses on this issue, it will help draw attention and resources—particularly at the national level—to this serious and growing public health problem. Moreover, Africa would benefit from USAID's extensive research, analysis, and dissemination experience to document the current situation and effectively present the problem to policy makers. The HHRAA Project's links to regional and subregional institutions will also help facilitate entry into countries to work on a subject that has been traditionally viewed as politically sensitive.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- International Projects Assistance Services (IPAS) has been conducting studies and supporting services related to the treatment of incomplete abortion in Africa for many years. Specifically, they have worked with institutions in Nigeria, Kenya, Zimbabwe, Ghana, Ethiopia, and Zambia.

- Population Action International provides training and equipment for the treatment of incomplete and septic abortions in several African countries, and helps fund selected IPAS activities.

- IPPF is studying abortion in six African countries. This activity is designed to give IPPF a general idea—rather than a rigorous data analysis—of the magnitude of the problem and the current policies and programs. The study was presented to regional FPA representatives at a conference in Mauritius (March 1994).

National Population Policies

Linkages to the Objective Tree

National population policies directly and indirectly affect family planning policies, service delivery, and demand generation. Current efforts to formulate national population objectives include helping countries to develop realistic and measurable demographic and contraceptive prevalence targets. Setting and officially adopting quantifiable objectives enhances political commitment and sector-level accountability toward achievement of goals. National policies directly address the issues associated with high fertility and rapid growth, and frequently emphasize family planning programs. Population policies indirectly advance the acceptance of family planning by supporting broad-based social sector programs to reduce maternal and child morbidity and mortality, focus on the needs of adolescents and youth, increase formal education opportunities, and enhance women's status. Improvements in these key areas have been linked to increased family planning demand and contraceptive prevalence.

Regional Significance

The formulation and implementation of national population policies is gaining momentum throughout the region. Creation of these policies and concern for their effective implementation are serving as an impetus to keep population and family planning issues high on national agendas.

Population experts also underscore the importance of placing special emphasis on fostering population policies and family planning programs in francophone Africa. Historically, francophone countries have assumed a more pronatalist stance than their anglophone counterparts, which was reinforced by colonial and religious attitudes, particularly in West and Central Africa. Although government attitudes and national policies are changing, strong pronatalist tendencies and sociocultural barriers to family planning persist.

USAID/Africa Bureau's Comparative Advantage

USAID, largely through the RAPID and OPTIONS Projects, has assisted many African governments to develop population policies and establish coordination mechanisms since the early 1980s. Thus, USAID is well placed to advance policy implementation by capitalizing on more than a decade of experience in Africa and other regions.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- The G/PHN/POP Office supports two projects aimed at strengthening national population policy efforts: (1) the RAPID Project, which raises leadership awareness of relationships between population growth and development; and (2) the OPTIONS II Project, which supports the policy development process and helps countries formulate comprehensive national population policies.

- The African Population Advisory Committee, funded by the UNFPA, IPPF, World Bank, USAID, and a number of individual governments, in collaboration with the Global Coalition for Africa, has proposed an intensified action plan to improve implementation of population programs. Key proposal objectives include assisting countries to operationalize population policies

(develop intensified country action plans); mobilizing human and financial resources for policy implementation; improving donor, government, and NGO coordination; and accelerating support for population initiatives at the community and grass-roots levels.

- The Center for Applied Research on Population Development (CERPOD), in collaboration with UNFPA and the USAID-funded OPTIONS Project, has been helping countries in the Sahel formulate national population policies. The next steps include sponsoring a series of workshops designed to assist governments to develop implementation frameworks and use demographic data in development planning.

Accelerating Urban Family Planning Programs

In Africa many family planning programs originated with a handful of clinics in the largest cities, usually run by private agencies or health providers. As programs expand, urban residents are clearly a prime audience for family planning programs: they tend to be better educated, more accessible, and more motivated to limit and space births than rural residents. Yet today, the demand for family planning in urban areas continues to outstrip available services. How can public and private sector providers mount more vigorous programs and intensify urban operations?

Linkages to the Objective Tree

Identifying what makes urban family planning programs successful, and determining how to use this information to improve service operations are directly linked to two objective tree targets: supporting policies conducive to better family planning operations, and improving family planning delivery. By establishing a network of high quality, convenient family planning services in urban areas, programs could build up a stable clientele and have a significant impact on the third target—generating demand.

Regional Significance

Africa is rapidly urbanizing and many villagers regularly travel to towns and cities. Historically, family planning acceptance has spread from cities to the countryside, and African countries appear to follow this example. Thus, it is important to have maximally effective urban family planning programs so

that they will serve as models for replication and attract more satisfied clients who will encourage others to adopt contraception. Comprehensive assessments of existing services could serve as the basis for new projects to upgrade services and as the rationale for directing bilateral assistance in a more concerted way to meet urban family planning needs.

USAID/Africa Bureau's Comparative Advantage

The G/PHN Population Office and USAID bilateral programs have provided technical assistance and financial support to promote African urban family planning programs through a number of cooperating agencies (e.g., Population Council, John Snow Incorporated, Pathfinder International). Building on these earlier country-specific initiatives, Africa Bureau and HHRAA Project staff can conduct cross-country comparative analyses, promote economies of scale in analyzing urban family planning problems common to several African countries, and take advantage of new linkages to regional institutions to collect data and disseminate results.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

The G/PHN Population Office, through agreements with a number of cooperating agencies, supports projects that work to expand and improve urban family planning services.

- The Population Council has conducted situational analyses in family planning clinics in several African countries and is eager to expand and apply this assessment framework to a variety of settings.

- John Snow Incorporated manages the SEATS Project, which works throughout Africa to develop innovative approaches to large-scale family planning program expansion. Technical staff are based in two regional offices: Harare and Dakar.

- Pathfinder activities include supporting community-based distribution programs, professional and paraprofessional training, clinical services, and institutional development efforts.

Vertical and Integrated Family Planning Program Approaches

Linkages to the Objective Tree

Assessing the effects of program structure on program performance could affect two population targets: improving family planning service delivery and increasing demand generation.

Regional Significance

Analyzing the performance of vertically organized family planning service delivery systems with that of integrated or various linked alternative networks is important for the subregion. Experience with different kinds of delivery systems is new and relatively limited. If one approach or combination proves to be markedly superior in output, use, and cost-effectiveness, this approach should be considered when new family planning programs are created or old ones expanded. Selecting the appropriate system is particularly relevant in designing delivery strategies for urban and rural settings or for countries with low-to-moderate levels of family planning demand, where population density and existing demand could significantly influence the cost effectiveness of a delivery approach.

USAID/Africa Bureau's Comparative Advantage

USAID's experience in designing and implementing vertical and integrated program structures in a variety of settings (public/private, low vs. moderate demand, etc.) provides an excellent basis for a more rigorous analysis. Assessing the relative contributions of different program components will help establish a rationale for African program design based on how integration in program structure and operations affects performance and which components are important and under what conditions.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- The Futures Group recently compiled a summary of family planning program structures with examples from each region.
- IPPF has extensive experience in using the stand-alone family planning clinic model associated with its private sector Family Planning Affiliates in several sub-Saharan Africa countries.

Framework Rationale: Information Needs and Gaps

For this framework, information needs and gaps are grouped into one of three broad categories:

- **Policy**—Which policies are most important in addressing population issues and reaching family planning service objectives in Africa? How can existing policies be improved? What steps are necessary to turn population policies into concerted actions?

- **Demand for and Supply of Services**—How can services be delivered and expanded to maximize efficiency, equity, and quality? Which factors influence behavior and practice, and what are the real constraints to change?

- **Costs and Financing**—How can governments meet the growing family planning demand when donor aid is unlikely to keep up with expanding services, and national budgets are under increasing stress? What are the best mechanisms for building consensus among policy makers regarding resource allocation issues?

Policy

This section focuses on two levels of policies that influence population growth and, specifically, family planning programs: (1) explicit national population policies, and (2) key sectoral-level policies. A national population policy is generally a statement or document by a national government announcing its intention or plan to affect the country's population growth and perhaps population distribution and/or composition (Isaacs, Cairns, and Heckel 1991). Although they may vary with respect to particular provisions, national policies usually contain a number of related elements including a rationale, goals and objectives, targets, program measures, and an outline of implementation and institutional arrangements.

Sectoral-level policies refer to sets of regulations or program protocols within one sector (e.g., health/family planning) that dictate courses of action for institutions and individuals. Throughout the issues identification process, experts underscored the importance of focusing on policies that directly affect access to reproductive health services. Although access can be hampered by a number of political, sociocultural, economic, religious, medical, or legal impediments, medical barriers were ranked consistently

as one of the five most important issues requiring attention. Therefore, most of the analysis presented in this section deals with barriers with a medical rationale.

National Population Policies

At the Third African Population Conference in Dakar (1992), leaders from the African region gathered to assess the implementation of the Kilimanjaro Plan of Action—a product of the 1984 Arusha Conference. It was clear that the spirit of Arusha has carried through the last decade, helping to keep population issues and policies at the forefront of development concerns. In 1980, only nine countries had policies aimed at lowering fertility. Today, 33 sub-Saharan African countries believe their fertility rates are too high. Eighteen have formulated and officially adopted explicit national population policies. Many of the remaining countries have either begun policy formulation or stated their intention to do so.

Conference participants agreed that that same spirit must now be harnessed to focus greater attention on the critical actions necessary for policy implementation. Despite the increasing number of explicit population policies, implementation has not evolved systematically. Most countries still indicate a pressing need for more data, and many problems persist in achieving desired program objectives. Frequently cited constraints include:

- a lack of quantifiable and realistic targets for resource planning;
- inadequate institutional infrastructure and coordinating mechanisms to implement and monitor policies and programs;
- weak political interest and commitment;
- low availability and use of reliable information for developing strategies;
- infrequent and low-quality program evaluations;
- low levels of participation by communities and local managers in policy and program design; and
- lack of national, subregional, and regional focal points to collate and disseminate population information.

No one is sure of the resources that have been and currently are being devoted to establishing of population policies in sub-Saharan Africa. What is evident, however, is that UNFPA and USAID have spent more than a decade providing technical assistance and financial resources to establish national population commissions, population planning units, and national population policies. These efforts have been supported by extensive documentation on the population policy formulation process.

Unfortunately, very little has been documented or disseminated regarding the actions necessary for policy implementation. The result is a dearth of knowledge about the steps beyond policy adoption. For example, in a recent national population policy implementation workshop held in Niger, the director of the National Population Directorate was unaware of steps any other country had taken to develop action plans or to sustain interest in population issues at the national and subnational levels. This is particularly disturbing because countries like Ghana, Nigeria, Zaire, and Zambia have extensive experience in consensus building and developing implementation frameworks. A few countries have even managed to increase national resource allocations to family planning programs owing to the policy implementation process. These and other country examples need to be documented and communicated to policy makers throughout the region.

Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access

Medical barriers, which constitute a significant limitation to contraceptive access in Africa, are defined as "practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception" (Shelton, Angle, and Jacobstein 1992). Major barriers include inappropriate eligibility criteria; process hurdles such as excessive laboratory testing; restrictions on who may provide contraceptives; provider bias; and lack of knowledge and counseling skills.

G/PHN/POP, working with USAID missions, USAID Bureaus, cooperating agencies, and other international organizations, is spearheading a global effort to reduce medical barriers through organized educational events, development of medical barriers guidelines, and country-level analyses. One activity was the development of a Medical Barrier Survey instrument. Surveys were sent to USAID Health and Population Officers requesting an

initial assessment of the situation in-country and suggestions for specific actions. The results of these surveys and the experiences of other experts working in Africa indicate a number of areas where lack of appropriate scientific information and gaps in documentation are impeding progress.

One of the most critical needs is to update service delivery protocols. In the majority of countries surveyed, providers require unnecessary medical tests and overly rigid follow-up schedules. For example, unwarranted "contraindications" to use of hormonal methods may be based on studies of high-dose estrogen oral contraceptives (OC), and may not be necessary for low dose OCs. For continuing OC users, most countries still require follow-up visits for resupply on a quarterly basis. In Tanzania, only one cycle is provided during each resupply visit. Stringent protocols also prevent women of certain age, parity, marital status, and spousal consent status from receiving contraceptive services, although there is no specific documentation indicating which criteria apply to each contraceptive method at the country level. Unnecessary age and parity restrictions are frequently found throughout the region. In general, inappropriate client eligibility requirements discriminate against groups that already face significant health or economic risks associated with pregnancy, e.g., adolescents and unmarried women. Overall, the surveys found that public sector services are more restrictive in nature than NGO services.

Other key areas requiring analytic activities are:

Improving service quality

Many medical barriers are constructed around life situations, notably age, parity, and marital status. Some counseling experts believe that providers who are accustomed to focusing on these concepts should be encouraged to continue doing so but for an entirely different purpose. Traditionally, providers are trained to offer family planning services based on a contraceptive-oriented approach. However, studies in Latin America show that providers can significantly enhance the quality of services by using a situation-specific approach to contraceptive distribution. This approach focuses on the reproductive life cycle of a woman and takes into consideration a number of factors such as age, marital and health status, and the advantages and disadvantages of various contraceptives given a woman's particular life situation.

Fostering policy and program level change

No comprehensive documentation exists regarding country-specific practices that affect access to family planning. The Medical Barriers Survey was meant to gather an initial range of opinions offered by regional counterparts. Although an important first step, it is not a comprehensive assessment at the country level. Moreover, to encourage medical professionals and leaders to advocate change at the policy and service delivery levels, more efforts need to be directed at documenting the positive outcomes resulting from reducing medical barriers. The wide dissemination and discussion of lessons learned could play an important role in fostering commitment to change.

Strategic approaches to reducing barriers

Once a needs assessment is completed, a systematic, integrated strategy for each country should be developed. According to one African family planning manager, "we need an affirmative program for what is an acceptable level of quality care [so that we can] then focus on removing barriers which clearly impede this program. Otherwise, we risk a piecemeal approach." Experiences from other regions indicate that organized educational events, such as regional workshops, can help initiate strategic planning processes.

Demand for and Supply of Services

Over the last decade, researchers have conducted a number of studies and surveys focusing on service provision and demand generation. The HHRAA Project undertook an extensive literature review of key population/family planning topics in this category to determine the availability of information, as well as the gaps. The topics were also reviewed by staff from various donors, cooperating agencies, and African institutions that have experience in these areas. The issues addressed in this section do not represent an exhaustive description of all potential research, analysis, and dissemination needs, but rather those that are cited most frequently as priority issues for sub-Saharan Africa.

Adolescent Reproductive Health

There is growing concern about the reproductive health problems facing adolescents in sub-Saharan Africa. At the 1992 African Population Confer-

ence, the majority of country delegates expressed the need to focus on youth and to establish or expand adolescent and youth programs. Problems most frequently cited are social and medical: the breakdown of traditional support structures, an early active sexual life, inadequate knowledge of reproductive biology, and limited awareness of and access to reproductive health services.

Owing to the Demographic and Health Surveys (DHS) we now have an unprecedented body of data documenting adolescent sexuality throughout the region. DHS data show that in the vast majority of countries surveyed, at least one out of every five young women, ages 15 to 19, had one child or more, or was pregnant at the time of the interview (PRB 1992). Liberia, Mali, and Uganda are at the high end: in these countries, 45, 51, and 37 percent of teenage women respectively, had given birth or were pregnant at the time of the survey. Unmet need for family planning among currently married adolescents ranges from 16 percent in Nigeria to 48 percent in Ghana, with need in most countries falling above 30 percent. In Botswana, Ghana, Kenya, and Zimbabwe, more than half of the unmarried, sexually experienced teenagers can be defined as having an unmet need for family planning.

Unwanted adolescent pregnancies often lead to unsafe, induced abortions (see Post-Abortion Management and Family Planning Service Provision). Studies in Kenya, Mali, Nigeria, and Zaire have indicated that between 38 and 68 percent of women hospitalized for induced abortions are aged 19 or less (International Center for Research on Women 1989). In a survey of young, unmarried Ibadan women, nearly all who became pregnant underwent voluntary, induced abortions. Among these women, only half were using contraception when they were subsequently surveyed.

In addition to DHS, which include some knowledge, attitude, and behavior questions, an estimated 40 sub-Saharan countries have conducted special KAP surveys for adolescents and youth. In general, attitudes vary widely and surveys often indicate a gap between knowledge and behavior. Despite widespread knowledge, only a small proportion of adolescents report ever having used a modern contraceptive. Many youth find it difficult or uncomfortable to talk about sexuality with their parents, family members, or other adults in general. Often the main sources of information are peers and the media.

What is needed now are wider, deliberate actions to address the issues, however complicated and politically sensitive they may be. Key information gaps and needed program actions are summarized below.

Increased understanding of adolescent knowledge, perceptions, and behavior

Few of the existing KAP studies include questions on STD/HIV/AIDS knowledge, perceptions, or behaviors. Moreover, the existing DHS data on adolescents do not include information on males, and several country surveys include only limited data on unmarried adolescents and youth. Thus, there is a need to obtain data on adolescents and young adults—both male and female, married and unmarried—that reflect more accurately the range of issues that programs must address in responding to the needs of these target groups. One example of an excellent, comprehensive survey designed uniquely for adolescents and youth is the Young Adult Reproductive Health Surveys. These surveys have been conducted since 1985 by family planning and youth organizations in Latin America, with technical assistance and coordination provided by the Division of Reproductive Health of the Centers for Disease Control and Prevention. They focus on a wide range of reproductive health issues and represent an excellent tool for potential application in the Africa region.

Identification of impediments to serving youth

In addition to gaining a better perspective on adolescent perceptions and needs, planners are beginning to look beyond youth to identify impediments to program implementation. Many African family planning experts now believe that the next step toward gaining acceptance of adolescent programs is to explore attitudes of parents, church leaders, service providers, and teachers toward sex education and reproductive health services. To date, there is very little documentation on how the roles, attitudes, and behavior of these target group members affect adolescent programs and contraceptive access in Africa.

Documentation and dissemination of successful programs

Programs focusing on adolescent reproductive health are fairly new in Africa; most are less than 10 years old. Nonetheless, there are a number of innovative and apparently successful programs, most notably in Nigeria, Sierra Leone, Tanzania, Kenya, and Ethiopia (Barker 1992). Since these ex-

periences have not been sufficiently documented and disseminated, it would be valuable to take a comprehensive look to better understand the context and the so-called recipe for their success, and to identify potential models for replication or future operations research studies.

Widening the range of youth interventions

According to a 1985 CPO survey, youth programs leaned toward multi-service centers and peer outreach, with 19 of 36 programs reporting that they promoted peer education. A survey taken in 1991 found that about half of Latin American and Asian programs featured peer education, and an estimated 13 percent promoted peer distribution of contraceptives. Moreover, many countries are becoming more creative in designing programs to reach youth. Nearly all emphasize that youth are best reached where they already congregate: in schools, on the street, in universities, in youth clubs, or at work sites. Operations research is needed to investigate strategies for reaching a variety of target audiences in this age group: hard-to-reach out-of-school, school leavers, and street youth; rural vs. urban youth; males vs. females; and youth from different socioeconomic backgrounds.

Improving the delivery of sex/fertility education

Family life education (FLE) programs have become indispensable for addressing adolescent problems in the region. Unfortunately, the content and methodologies used vary significantly. An International Center on Adolescent and Fertility Survey found that many FLE programs focus more on population education than on issues relating directly to family planning and sexuality (Barker, Hirsch, and Niedell 1990). Given the heavy reliance on FLE as a source of information for African youth, and the shortcomings expressed, efforts should be initiated to experiment with a broader range of activities and to consider more innovative presentations. For example, in Latin America, programs are moving away from didactic teaching methods and toward experiential educational methods. Programs in Asia tend to rely more on IEC materials, mass media, and libraries for passing information to teens than on the classroom setting. Peers reaching youth on their own turf may be the most effective way to encourage teens to adopt responsible behavior.

Increased advocacy efforts regarding adolescent fertility

Today, many countries have strong, vocal, and well-funded opposition to family planning for adolescents. Efforts to organize effective advocacy groups have not been as successful. Given communication difficulties in Africa, service providers and researchers throughout the region often work in isolation rather than joining forces. Support is needed to promote establishment of networks and joint advocacy organizations made up of professionals, family planning leaders, and donors. This effort could include research into different advocacy strategies, organizational models, and dissemination mechanisms to be used at regional and subregional levels. Advocacy efforts could be further strengthened by research showing the cost to African governments of the common sequence of school expulsion of pregnant schoolgirls, early childbearing, high parity and subsequent maternal and child health problems (burden of illness), long-term productivity loss, and costs associated with abortion-related morbidity and mortality.

Gender Issues in Family Planning

Traditionally, family planning programs in Africa have largely targeted women. With the current interest in exploring male attitudes, needs, and concerns, and the expansion of delivery approaches (employment-based distribution, contraceptive social marketing) that have a greater potential for reaching men, the emphasis appears to be changing. However, African experts caution against the inherent risks of reversing the focus and failing to recognize the importance of addressing the underlying and often more critical gender issues that influence family planning practices, such as the sociocultural environments that dictate gender behavior and couple interactions.

Representative studies of adult men available from 13 sub-Saharan countries show that men are usually in favor of family planning, desire more information, are frequently unaware of how to obtain services, and rarely discuss family planning with their partners. APAC has also recently conducted research through the group's Agenda for Action initiatives. These studies reveal that men are generally more interested in the relationship between family size and socioeconomic issues such as educational opportunities and jobs for their children than in health issues. Men perceive health issues as women's concerns.

Based on limited program experience in Africa to date, four strategies have the potential to promote greater male involvement in family planning: (1) subsidized retail sales; (2) work-site programs; (3) mass media campaigns directed specifically at males; and (4) community-based male distributors. However, few male programs have been evaluated to determine their impact, and little is known about the relative cost-effectiveness of alternative interventions.

According to the literature review and discussions with key African family planning informants, more research and analysis is needed to understand the male/female dynamics of decision-making and the kinds of male involvement that would result in the greatest benefits, e.g., increasing availability of male methods, expanding the number of sites where men can receive counseling and services, promoting joint decision-making. Would greater male involvement yield a significant payoff in increased contraceptive prevalence as compared with targeting females or couples?

Another crucial factor influencing family planning practices in Africa about which little is known is the African male proclivity for multiple partners. Research is needed to examine the underlying cultural and social factors that dictate male behavior. Knowledge gaps also exist regarding why some men feel responsible for family planning while other men don't, and the attitudes and practices of men who have relationships outside of marriage.

Furthermore, little attention has been directed to the social underpinnings of lineage systems and the various cultural associations that affect family size. A stronger understanding of the institutions that govern high fertility norms may be important in understanding decision-making processes and in developing more effective and responsive programs. These assessments should also include an examination of the roles of traditional leaders and opinion makers, and should identify mechanisms for mobilizing traditional channels for disseminating information.

Strengthening Reproductive Health Services: Integrating FP and STD/HIV/AIDS Programs

For many years there has been considerable discussion and literature devoted to prospects for integrating family planning efforts into programs to prevent and control reproductive tract infections (RTIs)[1], including AIDS. The debate has often proceeded on ideological grounds, and has lacked data reflecting actual experiences of field-based programs. Furthermore, focusing on how existing vertical programs for family planning and STD control can be formally integrated is often a "non-starter" because of the enormous difficulties encountered in Africa in combining budgets and bureaucracies (Elias, Leonard, and Thompson 1993). In many countries these two programs fall under different administrative authorities.

One approach is simply to respond to the problems of reproductive tract infections within the context of existing family planning programs. RTIs are of primary concern to family planning providers, as these infections influence the safety and quality of services, prevalence of infertility, demand for fertility regulation, and use of contraception. Therefore, the key research and analysis questions should not focus on how to integrate two separate government departments, but rather on how to expand existing family planning services to more adequately meet the reproductive health needs of the clients (Elias, Leonard, and Thompson 1993).

The extremely scant literature on incorporating RTIs, STDs, or AIDS efforts into family planning programs in Africa reflects not so much a lack of experience as a lack of effort to examine experiences, constraints, and effects of integrated activities. For example, an estimated 22 sub-Saharan countries have established condom social marketing programs that effectively integrate family planning and STD prevention activities. JHPIEGO, in collaboration with the World Health Organization (WHO), has worked to adapt simplified problem-oriented approaches to managing sexually transmitted genital tract infections for primary, secondary, and tertiary levels in several African countries. The Population Council OR/TA Project has completed projects dealing with diagnostic studies or technical assistance related to STDs or AIDS—notably in Burkina Faso, Gambia, Nigeria, Senegal, and Zambia (Population Council OR Conference, October 1993).

[1] There are three types of reproductive tract infections: sexually transmitted diseases, endogenous infections caused by overgrowth of organisms normally present, and iatrogenic infections associated with medical procedures.

Given that literature reviews reveal very few case study examples, there appears to be a need for a census assessment of integrated programs that highlights lessons learned. This assessment could include examples outside the region as well. The Population Council has demonstrated through operations research projects in Latin America that AIDS prevention activities can be successfully incorporated into the services offered by national family planning programs. A lessons-learned summary could also allay some of the concerns listed below that have been identified by family planning program managers, policy makers, and donors in Africa:

- attention to STDs and AIDS will stigmatize family planning and harm program performance;
- comprehensive reproductive health services are simply too expensive to even consider in resource-poor environments;
- family planning services are already overburdened and cannot accommodate expanded service obligations; and
- family planning clients are healthy people who will not appreciate being asked about or screened for diseases, such as STDs or AIDS (Elias, Leonard, and Thompson 1993).

The number of vertical, donor-driven programs, each with specific objectives and funding mechanisms, constitutes a major impediment to program integration. Guidelines are needed to clarify how donor organizations can coordinate family planning and STD/HIV/AIDS programs within the context of funding, strategic priorities, management considerations, and limitations of present cost-effectiveness studies (Bair et al. 1993). According to discussions and the literature, one critical area requiring additional research and analysis is development of methods to measure program success. What would constitute effective performance indicators for integrated programs? The reliance on current indicators such as "births averted" and "couple years of protection" does not adequately capture other important dimensions in the broader reproductive health area, e.g., client satisfaction, STD prevention (Shelton 1993).

Information is also needed regarding the costs associated with different service delivery approaches. Little is known about the relative cost-effectiveness of vertical vs. integrated approaches, the costs of providing condoms for primary prevention of RTIs, or how inclusion of screening and

referral for RTIs affects cost. Operations research projects to determine the cost-effectiveness of syndromic management of RTIs (diagnosing and treating clients on the basis of groups of symptoms rather than specific laboratory diagnoses—especially in women) would be useful in designing service delivery strategies. Syndromic validation studies are already in progress (by the AIDSCAP Project in Tanzania, Malawi, and Mali) and more studies are planned. WHO is also planning to compare the cost-effectiveness of syndromic diagnosis with laboratory and clinical diagnosis.

A final important area of research for Africa concerns the feasibility of clients adopting and using dual protection—condoms to prevent infection plus a so-called more effective contraceptive method to prevent unwanted pregnancy. No documentation is available on the implications of this strategy in terms of counseling, acceptability, compliance, or effectiveness. Similarly, more research is needed to explore the dimensions of acceptability and efficacy of female-controlled contraceptive methods to prevent RTIs, such as the female condom and a variety of vaginal spermicides. A related issue involves determining how existing family planning services can promote condoms more effectively to prevent RTIs—especially among men and youth. Given the number of condom social marketing projects in Africa, at least some answers to this question may exist, but data have not been analyzed or disseminated adequately.

Post-Abortion Management and Family Planning Service Provision

The World Health Organization estimates that 99 percent of the 500,000 maternal deaths that occur annually take place in developing countries; of these, an estimated 200,000 result from complications of illegal abortions performed by unqualified practitioners. In Africa, complications of unsafe abortion may be responsible for as many as 50 percent of maternal deaths.

Since abortion is a leading cause of disease and death among reproductive-age women in Africa, post-abortion management, counseling, and family planning service provision is an important area of concern. Evidence indicates that, in general, the potential target group—women who have had abortions—is not receiving effective contraceptive information or post-abortion family planning services.

Studies in Ghana revealed that 60 to 80 percent of minor operations performed at Korle-Bu Teaching Hospital were to treat abortion complications (Ladipo 1989). Among women giving birth at this hospital, 25 percent reported at least one induced abortion prior to the current hospitalization; the incidence was even higher among women with only one previous pregnancy (Lamptey et al. 1985). These results indicate that induced abortion is often used to delay a first birth. Unfortunately, adolescents are becoming increasingly disproportionately represented among women seeking abortions. Data from 13 countries show that girls aged 11 to 19 represented between 39 and 72 percent of all hospital admissions for abortion-related complications (IPPF, 1993). The tradition of family-based education—grandmothers talking about sex and reproduction with young girls in the family—has broken down. In most cases parents and teachers have failed to fill this knowledge gap.

Research on the topic is limited because of a reliance on hospital records and/or interviews with hospital patients. These data provide limited information on the epidemiology or incidence of abortion outside of those seeking treatment. Another gap observed in the literature is the relatively small number of recent publications. Following the Mexico City Population Conference in 1984, where a U.S. policy barring assistance to groups providing any type of abortion-related services was announced, the number of published studies dropped dramatically.

There are, however, several African countries where medical personnel have continued to gather data and have a significant amount of experience and knowledge about abortion-related mortality and morbidity (Ghana, Kenya, Nigeria, Tanzania, Zimbabwe). Much of this information has not been captured in existing data banks.

Abortion is an acute public health problem in sub-Saharan Africa that absorbs a large share of medical resources. Information concerning all aspects of abortion-related issues is urgently needed: primary data collection and secondary data analysis of the magnitude of the problem; costs associated with treatment of abortion complications; post-abortion care and management needs; experience with provision of post-abortion family planning services; and information about the cultural and socioeconomic dimensions of individual abortion behavior.

Accelerating Urban Family Planning Programs

Africa needs more highly visible family planning successes beyond Botswana, Kenya, and Zimbabwe. The Population Council recently conducted family planning clinic situational analyses in several sub-Saharan countries including Kenya, Tanzania, Zimbabwe, Nigeria, and Zaire. These analyses revealed that an estimated 15 percent of service delivery points provide 40 percent of services; another 20 percent provide 25 percent of services; and the remaining 65 percent provide 35 percent of services (Fisher et al. 1992). Increasing the productivity of clinics in the second highest 20 percent tier could prove to be a promising strategy. Preliminary analyses of potential causal factors from this study suggest that the more successful clinics are likely to have a larger proportion of staff trained in family planning, a wider array of available contraceptives (especially progesterone-only pills), IUD services, a clean examination area, and a source of potable water.

There were also a number of inconsistent findings among countries; for example, supervisory visits appear to be related to clinic productivity in Zimbabwe but not in Nigeria or Tanzania. To serve a larger number of family planning clients, more research is needed to identify the factors associated with success within different environments.

Population experts contributed the following suggestions for conducting a comprehensive urban study.

- Identify countries where the Population Council has already conducted situational analysis studies to explore the possibility of building on existing urban analyses.

- Investigate first-tier (high-impact) and second-tier facilities. The first tier could also be expanded in numbers served or types of services offered, such as voluntary surgical contraception.

- Assess the location of clinics with regard to public and private services. Public facilities may be underused or unnecessary in wealthy neighborhoods.

- Examine supply- and demand-side reasons for underuse.

- Assess the role of public provider salaries.

- Investigate the relationship between unmet need and low urban contraceptive prevalence.

Vertical and Integrated Family Planning Program Approaches

Traditionally, family planning service delivery strategies have been categorized as vertical or integrated structures. Past debate has centered on which approach is more effective. Vertical approaches were popular in the late 1960s and early 1970s when advocates of this structure felt that resources for family planning programs should be channeled into single-purpose organizations and that family planning clients' needs would not be lost in broader programs. This structure was also considered most effective in densely settled areas, e.g., urban areas, where there was a strong pre-existing demand for family planning. Proponents of the vertical approach have been concerned that family planning might lose its identity, as well as earmarked funds, if services were incorporated into a broader program (Gillespie 1985).

The concept of an integrated program structure may refer to management or service delivery or both. Characteristically, vertical programs are managed by an institutional structure with a single purpose, in this case providing family planning. The services may be offered at a single-purpose site and/or by single-purpose workers. Integrated management structures, on the other hand, describe an administrative hierarchy that performs a variety of functions in various fields. Family planning offered with an integrated approach typically means that these services are combined with maternal and child health (MCH), broader primary health care, or wider development activities such as education or agriculture.

By the mid-1970s, it became obvious that the vertical approach was not suitable for all regions. The integrated structure solved the problem of duplication of efforts and allowed for incorporation of family planning into existing management and health service networks. In addition, it helped to resolve friction between well-endowed family planning programs and the usually deprived, government-funded MCH programs. Integrated structures typically involve multiple institutions, inter-sectoral coordination, and joint use of resources. This approach proved to be more effective in low-density populations where it is more cost-efficient to deliver a variety of services at the same time. Furthermore, integrated programs are often more appropriate among populations with little demand for or knowledge

about family planning. The integrated approach allows family planning to be introduced in the context of broader health or development services.

Although most of the literature categorizes all program approaches as one of these two structures, one approach particularly relevant to Africa, albeit not widely incorporated into the theory, is the linkaged structure (Ickis 1987). Linkaged programs, which can be either vertical or integrated, describe services that are delivered by employing pre-existing infrastructures in the program design. For example, community-based distribution projects take advantage of community networks and leaders; social marketing builds on the existing commercial market system in a community.

This background suggests that to optimally organize family planning services in Africa, one must explore the relative advantages and disadvantages of the different approaches within a given context. It also suggests that it would be equally useful to disaggregate the components of program structure, determine if each component is vertically organized or integrated, and assess its influence on program output and service use. Additional information needs concerning program structure and performance include assessing the degree of integration within each program component—particularly looking at variables of organizational structure and operations; assessing the degree of component-specific integration and program outputs and service use; and examining the interaction among family planning demand, population density, and organizational program approach.

Costs and Financing

Family planning cost and financing issues are important in the African context. Justifications for focusing efforts in these areas include (1) stagnating or declining donor aid when demand is likely to grow; (2) avoiding the same problems encountered in the health sector where program implementation was impeded by a lack of adequate resources and understanding of cost and financial implications; and (3) developing the means to build consensus among policy makers regarding key resource allocation issues.

Cost Recovery

Cost recovery refers to charging family planning service users part or all of the costs associated with providing that service. Establishing cost recovery mechanisms requires detailed knowledge of the total costs associated with

providing the service (including capital, operating, and indirect costs) and the range of prices that can be charged to users of the service (what clients are able and willing to pay).

Cost recovery can simultaneously increase efficiency and equity of service delivery in developing countries. But whether these benefits are manifested in family planning programs that institute user fees depends on the overall health financing context, mix of public and private sector services, characteristics and demand patterns of the population served, clarity of objectives, and guidelines for use of revenue generated (Foreit and Levine 1993; Day 1993). As more African countries initiate national user fee strategies in their health care systems, it will become increasingly important to examine the effects of user fees on family planning services in particular.

Although there are few examples of successful, broad-based community financing schemes, some innovative programs exist. Under the Bamako Initiative, several studies were conducted to assess the potential for community financing of contraceptives. Community financing projects are underway in Kenya, Côte d'Ivoire, and Cameroon.

Another means of recovering costs is through cross-subsidization—using funds generated from one service to cover part of the cost of another. For example, in Colombia, a large family planning program (PROFAMILIA) raised about 30 percent of its income from fees for gynecological and urological services, treatment of infertility and sexually transmitted diseases, prenatal care, and general medical care. In Brazil, the private hospital Sofia Feldman pays part of family planning costs with revenues from laboratory analyses. In 1988, with support from the Enterprise Program, the hospital bought equipment to conduct parasitology studies, immunology analyses, and urinalyses. By mid-1989, laboratory revenues covered 45 percent of the hospital's family planning costs (Lande 1991). More efforts are needed to assess the scope of cross-subsidization of services in Africa by unit, service, level of income, or region. Family planning programs can draw from the wealth of research on cross-subsidization that has already been done in the health field. Producing an essay on cross-subsidization, similar to available user-fee manuals, would also be useful.

Public/Private Sector Collaboration

In sub-Saharan Africa many questions exist regarding the role and function of the private sector in family planning. There has been limited documentation of the scope, scale, location, and number of clients served through private services. The Health Financing and Sustainability Project is beginning to study these questions for health services and could include family planning services. In general, these studies look at for-profit and non-profit sectors, employer-based services, private insurance, and questions concerning public/private relationships (e.g., are private services being crowded out by subsidized public sector services)? The Futures Group, under the OPTIONS II Project, is examining laws, regulations, and operational policies that increase the cost of commodities, training, and equipment to levels that make family planning services prohibitively expensive for private providers (Kenney 1993). OPTIONS undertakes special studies to promote expansion of private services. These studies include legal and regulatory analyses of the private sector, market segmentation surveys, and price sensitivity of demand analyses to project the potential impact of introducing new brands and products at a range of prices (Bennet, Smith, and Smith 1993).

Another important question is how to convince policy makers to provide subsidies and grants to non-governmental organizations (NGOs). This effort requires sensitizing policy makers to the benefits of shifting activities to the private sector. Target audiences should include ministers of finance and plan, and not just representatives of health and family planning departments. Employer-based strategies, particularly the Enterprise and TIPPS Project experiences, should be widely disseminated. Moreover, with more than 22 sub-Saharan African countries implementing contraceptive social marketing programs, there is a need to analyze cost implications and disseminate results (PSI and SOMARC).

Costing Methodologies

A critical problem in determining overall family planning costs is that many different methodologies are used. Economists suggest selecting and supporting one methodology and disseminating it widely. An associated problem is the use of macro-level costing methodologies versus those used at the service delivery level. Information is needed to determine how well economic costs can be calculated at the local level.

Project designs should incorporate specific sections devoted to family planning costs. Programs should define objectives at the outset and indicate where resources should flow and in what quantities. To assist with this exercise, more emphasis should be devoted to gathering and analyzing cost data from different countries at various levels of family planning program development. Cost data can then be plugged into existing models to improve planning processes. Cost information gaps exist for a number of variables including different modes of service delivery, integrated vs. vertical settings, urban vs. rural, low vs. high income levels, and low vs. high contraceptive prevalence.

Project designs must also consider demand- as well as supply-side variables. How important are total private costs to individuals? Can they act as barriers? Before proposing specific delivery modes, such as community-based distribution, there is a need to study fixed clinic vs. CBD/mobile units or social marketing strategies to determine which has resulted in reduced private costs to users.

Resource Allocation, Use, and Management

More African countries are working to decentralize health and family planning services. Thus, more emphasis should be placed on examining the effects and benefits of decentralization, including retention of user-fee revenues and authority to allocate local-level resources.

Program managers also need to be reminded of the importance of costs and financing in determining long-term program success. Disseminating financial management tools (manuals, handbooks) to program managers, and involving them in the budgeting process, may help raise awareness and interest in family planning resource management.

Cross-Cutting Issues

The following issues cut across several sectors, but are included under this framework because they contain elements that are important for achieving population and family planning objectives: (1) program decentralization, and (2) assessing manpower deficits.

Decentralization

Decentralization in the African context has been defined as "a transfer of decision-making and executive power from the central level to the local or peripheral level, with the central level maintaining a guiding role" (Vriesendorp et al. 1992). This transfer results in total autonomy. In this system the central body does not concentrate on the process, but on what the local level must produce. To function independently, the decentralized unit must become a legal entity.

The essential goal of decentralization is to streamline the tasks involved in serving the client population. Commonly stated prerequisites for decentralized management include the political will to decentralize, competent personnel at all levels, implementing mechanisms, a legal-administrative framework, resources, and involvement of local leaders. Advantages of decentralization include the following:

- enhanced satisfaction of the population's needs,
- increased accountability of personnel,
- improved resource management,
- efficient resource distribution,
- rapid decision making closer to the level of implementation,
- reduction of central level's work load,
- improved integration of activities, and
- program expansion and sustainability.

Decentralization is a priority issue in most sub-Saharan African countries. Because total decentralization is difficult to accomplish, some countries are beginning deconcentration—the partial transfer of decision-making and executive power, which results in conditional autonomy. Family planning experts believe that family planning could be the motor that drives changes in management systems, particularly in the health sector. For example, action plans in a number of countries include activities designed to decentralize selected activities: in Rwanda, 50 percent of the training program has been decentralized; Togo has adopted a decentralized manage-

ment system with seven branch offices; and Morocco is in the process of decentralizing supervision with the establishment of integrated teams at the regional and provincial levels (Vriesendorp et al. 1992).

More support is needed to document, monitor, and disseminate the implications and consequences of decentralization within family planning programs. In the larger context of national decentralization efforts, could lessons in family planning programs be generalized to other sectors? Are experiences in other ministries/sectors useful for population programs? Because decentralization affects several management areas, most notably human and material resources, finances, data use, and organizational structures, are there overlapping program elements where intra- or intersectoral efforts could be initiated?

Human Resources: Assessing Manpower Deficits

Recent interviews during visits to Botswana, Malawi, Uganda, and Zambia, and discussions with USAID staff from Zimbabwe have highlighted the severe physician shortage. Over the past few years this situation has been exacerbated as more and more physicians migrate to South Africa where salaries and professional opportunities are strikingly better. Illustrative of this shortage is the fact that in Malawi, all or almost all of the approximately 20 medical officers are expatriates. Comparable evidence exists in Botswana where expatriate district medical officers are the norm, not the exception. In Zambia, public sector clinics frequently function without physicians.

There is no short-term solution to this shortage of physicians. If it is ever resolved, it will only occur after sufficient numbers of physicians have been trained to saturate the market, and the currently attractive alternative of migration no longer exists. In the meantime, governments need to consider alternative health manpower strategies to ensure continuing access to quality primary health care services. One alternative is to adjust current policies, as well as pre- and in-service training curricula, so that nurses and paraprofessionals can assume more of the responsibilities currently carried out by physicians.

Information gaps and needs in this critical area include (1) documenting the extent of the physician shortage and its impact on health care; (2) determining what changes in policies, regulations, and practices have to be

instituted to fully implement a nurse-based health delivery system; and (3) promoting advocacy efforts to remove potential barriers. Examples of overcoming barriers include authorizing non-physicians to carry out certain procedures and prescribe medications, allowing nurses to insert IUDs and NORPLANT or provide injectable contraceptives, and permitting non-physicians to occupy management positions at all levels of the health care system.

Potential Approaches to Address Priority Needs

Based on USAID/W's population and family planning focus, relevant literature reviews, priorities specified by African and international experts, and issues identified by participants at various workshops and recent conferences, the following activities are presented as potential approaches to address the needs and information gaps listed in the previous sections.

Adolescent Reproductive Health

- Conduct additional studies to assess the attitudes, knowledge, and practices of married and unmarried, male and female adolescents and youth in sexuality and reproductive health needs, including STD/HIV/AIDS information and services. Studies could be conducted with assistance from the CDC, using the Young Adult Reproductive Health Surveys.

- Identify impediments to establishment and expansion of programs by assessing the attitudes of parents, church leaders, service providers, and teachers toward sexuality, education, and reproductive health services for youth.

- Document, analyze, and disseminate successful adolescent/youth programs to develop a better understanding of recipes for success and to share lessons learned.

- Conduct research projects to identify different approaches to reaching youth (e.g. out-of-school programs, in-school programs, social marketing, media).

- Support development and use of an Adolescent Advocacy Training Module to help program managers and interested advocates sell their issues to policy audiences and the media. The Center

for Population Options (CPO) is in the early stages of designing the module in collaboration with members of the Nairobi Centre for Adolescents.

- CPO has a generic set of Family Life Education modules that they have adapted to a variety of settings and target audiences (e.g., in-school youth, out-of-school youth) in Latin America. These modules could be tested in and adapted to the African context.

- Support networks and joint advocacy groups by implementing conferences and workshops that provide forums to present research and analysis results, and promote region-wide strategies for affecting policies and programs. CPO is requesting assistance in supporting the African Association for the Promotion of Adolescent Health—a network of leaders devoted to establishment and expansion of adolescent programs. Activities could include the following. (1) support for reproduction and dissemination of a videotape produced during the First Inter-Africa Conference on Adolescent Health (Nairobi, March 1992); (2) assistance with organization of a regional steering committee meeting; (3) support for regional or subregional adolescent conferences.

- Examine national costs associated with (1) adolescent abortion-related mortality; (2) the sequence of early school dropout due to pregnancy, early childbearing, high parity, and subsequent maternal and child health problems; (3) loss of productivity; and (4) the burden of illness. Disseminate these data to high-level policy makers, community leaders, donors, and representatives of advocacy networks.

Reducing Medical and Other Barriers to Family Planning Access

- Help to with conduct country-level assessments (situational analyses, review of current guidelines) and develop a typology of barriers by country (*de facto* and *de jure*). Assessments can be carried out in conjunction with subregional medical barriers conferences (JHPIEGO, FHI, INTRAH) and disseminated to policy makers, medical association leaders, family planning trainers, program planners, and donors. Final document could also include case studies (see below).

- Document and disseminate case studies that depict positive changes resulting from reduction of medical barriers. Studies should highlight improvements in service quality and client satisfaction.

- Support workshops and conferences that provide scientific information, promote exchange, foster ownership, and encourage development of systematic, integrated action plans. Follow-up on conferences to assess country-specific program impacts. Activities should be carried out through the R&D/POP working group responsible for Organized Education Events.

- Develop situation-specific decision trees to improve provider counseling and quality of care:

  - Develop family planning algorithms for doctors and nurses based on client-oriented, rather than commodity-oriented, approaches.
  - Field test prototype manual.
  - Produce and distribute pocket-size algorithms for providers.

  JHPIEGO is implementing this activity in Latin America and could help to develop similar algorithms within the African context.

- Document the extent of the physician shortage and its consequences. Examine alternative health manpower models focusing on nurses and paraprofessionals, and outline a strategic approach for executing policy and curricula changes that will permit maximum use of nurses, midwives, paraprofessionals, and auxiliary workers.

Gender Issues in Family Planning

- Conduct impact assessments on existing projects and programs that target male involvement.

- Analyze existing studies and conduct additional research as necessary to identify sociocultural factors influencing gender behav-

ior, couple interactions, and decision-making processes. Apply findings to IEC and service delivery approaches.

- Analyze KAP-related variables for husbands and wives for those surveys carried out during the DHS I and DHS-II in which couple records can be linked. Prepare and disseminate a comparative study of husband and wife attitudes under the DHS Comparative Working Paper Series.

- Support local costs and provide technical assistance to in-country DHS teams to conduct a more detailed analysis of DHS III male modules. This activity would use the new model developed by Macro designed to assist local researchers in further analysis of male survey data. Training and analysis could be implemented through subregional research institutions like CERPOD.

- Support operations research projects to identify (a) payoffs of investing in activities targeting males versus females or couples; (b) types of male involvement approaches that are the most effective: male method promotion versus couple (spousal) communication promotion, etc.; and (c) the most effective delivery sites for men, e.g., work sites, men's groups, traditional and nontraditional commercial outlets.

Strengthening Reproductive Health Services: Integrating FP and STD/HIV/AIDS Programs

- Assess existing integrated family planning and STD/HIV/AIDS programs in Africa with examples from other regions, highlighting experiences, impact, and lessons learned. Prepare a summary booklet for African policy makers, family planning managers, and donors.

- Support workshops/seminars designed to examine donor implications of integration of family planning and STD programs. One potential forum might be the annual USAID/W conference sponsored by the Africa Bureau (last year's topic: Population and the Environment). Workshops should address the following:

    - How can donors overcome population vs. health polarity regarding funding sources and objectives?

- What would be the program performance indicators of an integrated program? What are the trade-offs between family planning and health objectives?
- What major criteria should be used to determine relative funding levels among elements of a comprehensive reproductive health program?

- **Support** analytic activities and research efforts to determine the costs of different service delivery approaches—integrated vs. vertical, primary RTI prevention, and RTI screening and referral. Examine the cost-effectiveness of various integrated service models and syndromic diagnosis of RTIs vs. laboratory diagnosis.

- **Assist** with studies to determine the feasibility of dual protection among family planning clients. These studies should address the counseling, acceptability, compliance, and measurements of effectiveness of this strategy. This effort could also involve studies to learn more about female-controlled methods and their acceptability and efficacy in preventing RTIs—such as the female condom and various vaginal spermicides.

Post-Abortion Management and Family Planning Service Provision

- Conduct secondary analysis of existing data, and primary research in selected countries on the number of incomplete abortions (urban, periurban, rural); post-abortion family planning services; costs related to abortion morbidity and mortality with special emphasis on adolescents and youth; attitudes and perceptions from health care providers and clients; and policy and program implications. Research and analytic activities should be carried out in anglophone and francophone Africa.

- Prepare technical reports and policy booklets designed for African policy makers, family planning managers, health providers, and donors. Consider producing a computerized storyboard presentation of morbidity and mortality data; cost data, impact, and policy implications. This type of presentation would benefit from The Futures Group's experience in RAPID type computer models.

- Examine the sociocultural dimensions of abortion behavior. Questions requiring additional study include:

  - How does a woman make the decision to end her pregnancy? What and who (enablers) influences her?
  - Are women who turn to abortion former users of contraceptive? If yes—why did they discontinue contraceptive use?
  - What do women know about the potential health and psychological risks associated with abortion?
  - What could have helped prevent an unwanted pregnancy? Are women aware of alternatives to abortion? What barriers exist to obtaining contraceptive information and services?

The results of this type of data collection could be used to develop more appropriate education, counseling, and family planning programs for this important target group.

National Population Policies

- Support seminars to (1) review experiences to date regarding national population policy implementation, (2) develop more comprehensive strategic planning approaches, and (3) disseminate existing instruments and computer models that can be used for data collection and analysis and for integrating population data into development plans. CERPOD facilitated a francophone seminar in FY94. The Futures Group provided technical assistance and partial seminar funding.

Accelerating Urban Family Planning Programs

- Conduct an assessment of four to six urban family planning service delivery programs to determine their: (1) adequacy in terms of coverage and capacity to meet demand; (2) absorptive capacity; (3) reasons for success with regard to contraceptive prevalence; and (4) quality of services provided (e.g., are they offering a full spectrum of contraceptive technologies and appropriate client counseling?)

Vertical and Integrated Family Planning Approaches

- Compare the performance of vertically organized family planning delivery systems with integrated approaches within a variety of environmental contexts (e.g., low demand vs. high demand, low vs. high population densities).

Cost Recovery

- Assess the scope for community financing of contraceptives by analyzing projects carried out under the Bamako Initiative.

- Assess the scope for cross-subsidization of family planning services by region, income, or type of service. Produce a handbook for family planning managers similar to the recent manual produced by John Snow, Inc., on user fees.

- Study the influences of price on contraceptive use in different modes of delivery.

Public/Private Collaboration

- Assess the scope, scale, and location of clients served by private providers.

- Sensitize policy makers to the benefits of subsidies to NGOs to expand service delivery.

- Analyze the lessons learned in social marketing public/private collaboration (e.g., PSI and SOMARC) and disseminate the results to a broad range of policy makers and opinion leaders.

Costing Methodologies

- Establish a standard definition and methodology to calculate the cost of providing family planning services, then promote it. One suggestion for a standard approach is a handbook currently being developed by Barbara Janowitz of Family Health International.

- Use this approach to carry out thorough costing exercises in several countries, including those at different levels of family planning program development and with various delivery modes.

- Plug empirical cost data into existing models (e.g., target-cost) to improve the accuracy of strategic planning throughout the region.

- Assess and synthesize the existing cost-effectiveness literature, particularly to highlight the cost implications of (1) demedicalizing services, (2) integrated vs. vertical services, (3) different method mixes, and (4) urban vs. rural strategies.

- Help enhance policy makers' understanding of the importance of cost recovery as a means to expand access to low-cost, high-quality services.

- Sensitize policy makers to the importance of including costs in strategic planning, even in cases where most funds come from donors. Morocco is shifting contraceptive costs from donors to the government; this effort would provide an excellent case study.

- Develop a better understanding of the full range of costs to individuals of accessing family planning services. Information could be gathered through a special DHS module on private costs and household expenditures.

- Carry out a thorough cost comparison of family planning service delivery in the public and private sectors.

Decentralization

- Examine the benefits of decentralization, including retention of fee revenues and power to allocate resources.

- Support national decentralized data analysis and application. CERPOD is developing a module designed to teach data management, analysis, and use to local-level statisticians.

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Annex: Results of Priority Issues Questionnaire/Respondents

Health and Human Resources Analysis for Africa (HHRAA) Project
October 21, 1993

At the recent Population Council Operations Research End-of-Project Conference in Nairobi (October 4-7, 1993), HHRAA Project staff administered a questionnaire asking selected conference participants to rank order (1-10) the following potential research, analysis, and dissemination topics. The following results include a listing of the topics from most to least important, other topics suggested by the respondents, and additional comments.

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
1. Adolescents and youth. Many African countries are expressing the need to establish or expand adolescent and youth programs. Examples of specific needs include expanding and improving Family Life Education (FLE) programs and exploring attitudes of adolescents, parents, service providers, and teachers towards sexuality and adolescent reproductive health services.	• Church leaders need to be addressed fast and foremost. • Need to address service delivery needs of youth beyond FLE, and look beyond youth-only models which may not be sustainable. • No donors want to help. • Must look into peer group education strategies, too. • What about improving girls' self esteem, empowering them so they can make informed choices about their sexuality and reproduction.
2. Medical barriers to increased family planning acceptance. Barriers are practices that result in an unjustifiable impediment to, or denial of, contraception. Major barriers that continue to limit family planning expansion include unnecessary restrictions on eligibility criteria or on who can distribute contraceptives and perform procedures, quality of care issues, and lack of knowledge and counseling skills.	• Service provider skills and attitudes are coming out as important factors influencing acceptance and continuation. • Some of the barriers are legal. The rules need to be changed. • Need an affirmative program for what is an acceptable level of quality care: then focus on removing barriers which clearly impede this program. Otherwise, risk piecemeal approach. • Include political and religious barriers - particularly for the benefit of adolescents.
3. Male involvement in family planning. How can we better address male attitudes, needs, and concerns about family planning? Research and analysis activities could include increasing our understanding of male/female decision-making and determining what type of male involvement would result in the greatest benefits.	• General gender bias of FP programs should also be looked into. • The current failure to reach and convert women is because of fear of men and failure to educate men to be involved in FP. • More anthropology and ethnic skills are needed in this research area. • Problem here is partly education and partly programmatic. • What are the community factors that influence male dominance? • FP information gap among males. Expand to include general gender issues.

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
4. Integrating family planning and STD/HIV/AIDS programs. Currently, there are a number of projects within countries aimed at integrating services, although few integrated programs exist on a national level. How can we facilitate program integration and donor project coordination when it is appropriate?	• Note that ZNFPC in Zimbabwe is just beginning a national-level STD/FP integration program. • The issue is not the integration of two programs, but making FP relevant to the sexual lives of people, their concerns and sexual interactions. This will impact safe sex and sexual health in general as well as covering gender issues. • What about integrating FP with child care services as well? There are more natural links here! • Add RTIs!
5. Incomplete abortion management/post-abortion contraception. As a leading cause of disease and death among women of reproductive age in Africa, abortion and related services such as post-abortion management, counseling, and family planning are becoming focus areas of concern. Topics requiring further research, analysis, and dissemination include collecting data related to incomplete abortions; post-abortion services; costs related to abortion morbidity and mortality; and policy implications.	• Prevention of unwanted post-abortion pregnancy cannot be overemphasized. • Policy issues are the most important concerning abortion. Unless governments facilitate access to safe abortion, it will cause great damage to FP programs in Africa. • Abortion is a problem, but should be covered when barriers are removed. Post-abortion services are already available in many countries. • Very important. What about caring for complications of incomplete abortion?
6. Decentralization. Decentralization is a process in which the central level transfers decision-making authority to the local or peripheral level. The essential goal is to streamline the tasks involved in serving the needs of the client population. Since this process can affect several management elements, most notably human and material resources, finances, information, and organizational structures, what are the implications for family planning services? How can countries better serve dispersed populations?	• It's obvious that central authority is unable to manage development programs. Authority and resources should be decentralized. Field people must be empowered to carry out their activities. • Need to help decentralized managers better analyze existing data. • Delegating power in a paternalistic country is a very difficult (delicate) task that requires urgent attention from officials and African researchers.
7. Strategic planning for family planning resources. Family planning programs should clearly define objectives at the outset and give an indication of where resources should flow and in what quantities. Existing models (for example, Target-Cost) could be tested for their usefulness for strategic planning.	• More needs to be done to tap local non-health resources, i.e., agriculture, livestock projects. • So much of this has been done in Zimbabwe (for example) it's not a pressing area. • Also a need to define boundaries of program activity. • As much as possible, the outcomes should be impact rather than/not only process indicators. • Models are not only useful for strategic planning but effectiveness or impact outcomes

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
8. Contraceptive discontinuation. Discontinuation plays a significant role in the number of clients lost from family planning services each year. How can service providers help ensure client satisfaction and lower discontinuation rates? What is responsible for the wide gap between ever use and current use of contraceptives?	• This is a big problem with insufficient attention. • Need update/refresher courses with emphasis on counselling skills. • If proper counseling is done, this will not be an issue. • To diminish discontinuation, need to improve management of side effects.
9. Family planning program costing methodologies. An accurate assessment of the costs of different types of service delivery approaches in different settings (for example, private vs public) is crucial to designing an effective family planning program; yet there is no standardized, user-friendly costing methodology currently available. Such an approach could be developed and widely disseminated.	• There is too much stress on "costs" in Africa FP programs. • Will this include cost-effectiveness? It should. • Assess how fee-for-services is or is not a barrier to FP services in poor-income population groups. • Zimbabwe is doing this now. I'm sure other African countries will follow suit soon. • In most countries, the political arena needs to be looked at if this area is to succeed. • In general, FP programs don't plan costs. This is the reason they are so unlikely to be sustainable
10. Cost recovery. There are a variety of approaches that family planning organizations can use to recover some of their costs, many of which have been successfully used for health services. Research and analysis activities could be undertaken to study different approaches and to determine which would be most appropriate in different African settings.	• It's time countries begin to show FP is in relation to socioeconomic development. It should be paid for like other services, e.g. education, curative treatments, etc. • Is cost-recovery the answer under high levels of poverty? The issue first is to provide acceptable FP, then people will "buy" it. Don't cost-recover what is embryonic because it may aborti • The Bamako Initiative is a real strategy, presented within the context of community health. It is important to use this channel. • I don't know of many successful health service cost-recovery efforts. • Goes hand-in-hand with cost methodologies. How do you know how much you need to recover, if you don't know how much it costs in the first place?.
11. Public and private sector collaboration. In Asia and Latin America, the private sector has played a pivotal, cost-effective role in family planning service delivery. An assessment could be undertaken to examine the potential for the private sector in Africa, and to identify ways in which private and governmental organizations could collaborate.	

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
12. Resource allocation, use and management: Many African countries are working to decentralize the delivery of health and family planning services. What are the effects of decentralization on the cost of family planning services, the retention of user-fee revenues, and on the authority to allocate resources?	

Other topics listed by respondents in order of ranking:

- Community perspectives of the design and implementation of FP programs. (1)
- Does Non-Project Assistance (NPA) work? Several African countries receive NPA on population policy change. How does NPA affect policy, government financing, dependency on donors? What modalities and conditionalities do other donors use? (1)
- Problems of KAP/GAP. (2)
- Service delivery strategies, i.e. how to ensure service delivery availability to prospective users in a manner that is acceptable to the user. (3)
- Interaction between child survival, family planning, and safe motherhood. (4)
- Social, economic, and health benefits of family planning (with an emphasis on documenting and disseminating information). (5)
- Service Quality: Control of RTIs to assure women and protect them from existing and perceived health risks. (10)

Other non-ranked topics listed by respondents:

- Targeting the politicians to educate them on family planning issues, particularly relating to adolescents.
- Impact of social changes (democratization, decentralization, privatization, etc.) on FP programs.
- How to expand long-term/permanent methods?
- More qualitative studies on users, non-users, and potential users, beliefs, attitudes beyond knowledge and practices. What are people's concerns about FP and modern contraception?
- What parts of program failures are related to donor pressures and requirements for immediate outputs?
- Methods of training staff about sexuality, allowing them to review own attitudes and beliefs, and become comfortable in discussing sexuality.
- Strengthen CBD programs at the grass roots level.

RESPONDENTS

- PRIORITY ISSUES QUESTIONNAIRE - POPULATION

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